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The Patient-Centered Medical Home

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Topics

1. The Case for Health Care Reform
2. What is Patient-Centered Care?
3. What is Primary Care?
4. Patient-Centered, Physician-Guided Care
5. Why is Primary Care Important?
6. What is the Patient-Centered Medical Home?
7. Joint Principles of the PCMH
8. Four Critical Questions
   a. Recognition
   b. Cost
   c. Quality/Cost Impact
   d. Satisfaction
8. Potential Health System Impact
9. Specialty Care Connections
10. Expanding Interest
11. Demonstration Projects
12. Payment Models
13. Practice Implications
14. Health Information Technology
15. Health Care Industry Implications
16. The Future

The Case for Health Care Reform

- **Poor access to care, especially for the uninsured**
- **Escalating costs & volume of services**
- **No link between cost and quality**
- **Excessive administrative costs**
- **Dysfunctional payment system**
- **United States is <u>lagging</u> internationally**

What is Patient-Centered Care?

- **One of IOM's six domains of quality**
- **Picker Institute – 8 dimensions of care**
- **"Nothing about me without me"**
- **The right care in the right way at the right time**
- **Providing the care that the patient needs in the manner the patient desires at the time the patient desires**

## Attributes of Patient-Centered Primary Care

- **Superb access to care**

- **Patient engagement in care**

- **Clinical information systems that support high-quality care, practice-based learning, and quality improvement**

- **Care coordination**

- **Integrated, comprehensive care; smooth information transfer across a fixed or virtual team of providers**

- **Ongoing, routine patient feedback to a practice**

- **Publicly available information on practices**

Davis, K., Shoenbaum, S., Audet: A 2020 Vision of Patient-Centered Primary Care JGIM 2005; 20:953-957

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Patient-Centered, Physician-Guided Care

Integrated Delivery System *or* Virtual Team

Practice Team

Physician   Patient

Family

Community
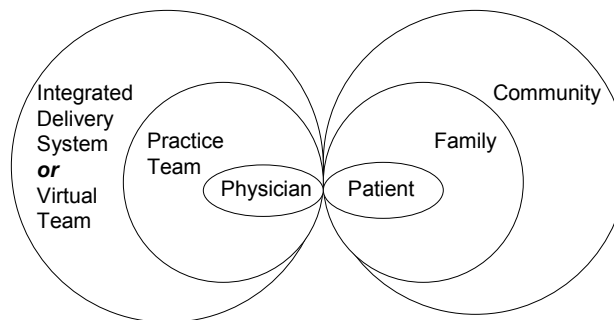
Team ▷

Adapted from:
Defining Primary Care: An Interim Report, Institute of Medicine 1994

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Why is Primary Care Important?

- Better health outcomes☼

- Lower costs☼

- Greater equity in health☼
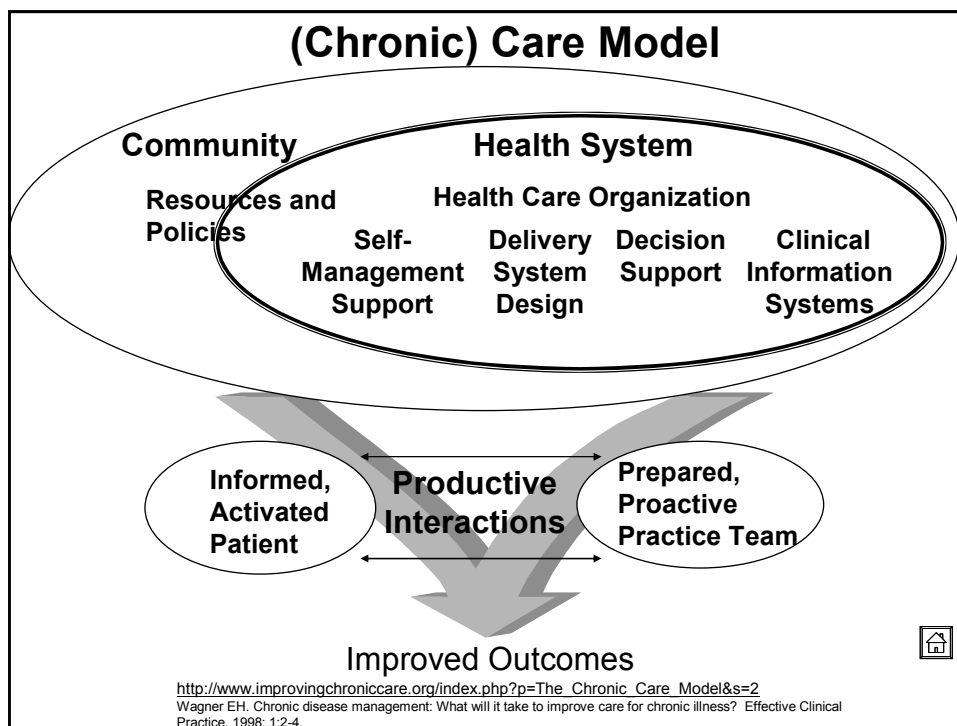
What is the Patient-Centered Medical Home?

- …a vision of health care as it should be

- …a framework for organizing systems of care at both the micro (practice) and macro (society) level

- …a model to test, improve, and validate

(Chronic) Care Model

Community   **Health System**

Resources and Policies

Health Care Organization

| **Self-Management Support** | **Delivery System Design** | **Decision Support** | **Clinical Information Systems** |

Informed, Activated Patient   **Productive Interactions**   **Prepared, Proactive Practice Team**

Improved Outcomes

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998; 1:2-4.

The Joint Principles of the PCMH

- **Personal physician**
- **Physician directed medical practice**
- **Whole person orientation**
- **Care is coordinated and/or integrated**
- **Quality and safety**
- **Enhanced access to care**
- **Payment to support the PCMH**

Team-based care:
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Community resources
DM companies
Others…

Team ▷

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Professional Societies Endorsing Principles

- American Academy of Hospice & Palliative Medicine
- American Academy of Neurology
- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Cardiology
- American College of Chest Physicians
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists

- American College of Physicians
- American Geriatrics Society
- American Medical Directors Association
- American Osteopathic Association
- American Society of Clinical Oncology
- American Society of Addiction Medicine
- Society for Adolescent Medicine
- Society of Critical Care Medicine
- Society of General Internal Medicine

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Four Critical Questions

1. **How do you know a PCMH when you see one?**

2. **What does it cost?**

3. **Will it improve quality and reduce cost?**

4. **Will patients be satisfied?**

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Challenge: Define the Medical Home

- **Recognition tool**
- **Independent, third party entity**
- **Alignment with the PCMH attributes**
- **Flexible**
- **Road map for practices to evolve over time**
- **Applicable to practices of different sizes**

Health Care in the US = Small Offices

- **"During 2003–04, there were, on average, 161,200 office-based medical practices in the United States involving 311,200 physicians"**

  - **Estimate of total office visits: <u>908 million</u>**

- **"Solo physician practitioners, who constituted 69.2 percent of all practices but 35.8 percent of all physicians, had 36.8 percent of all office-based visits"**

  - **Interpretation: <u>334 million</u> visits in small offices** ☼

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NCQA:
Physician Practice Connections/PCMH

1. **Access & Communication**

2. **Patient Tracking & Registry Functions**

3. **Care Management**

4. **Patient Self-Management Support**

5. **Electronic Prescribing**

6. **Test Tracking**

7. **Referral Tracking**

8. **Performance Reporting & Improvement**

9. **Advanced Electronic Communication**

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Building a Ladder to Excellence
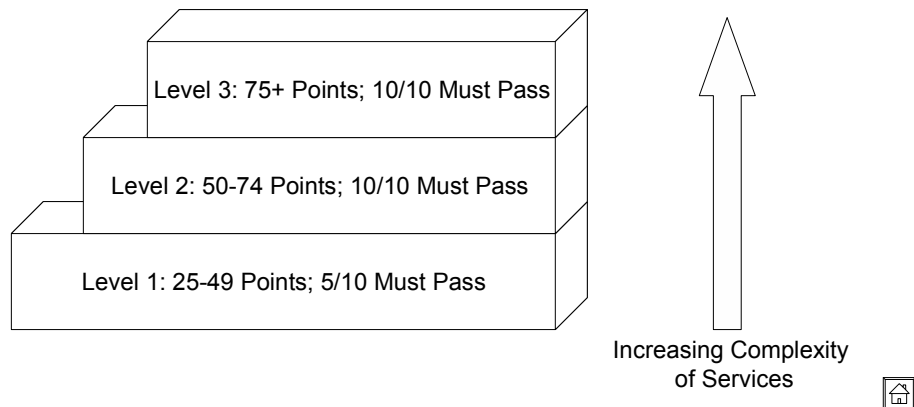
Level 3: 75+ Points; 10/10 Must Pass

Level 2: 50-74 Points; 10/10 Must Pass

Level 1: 25-49 Points; 5/10 Must Pass

Increasing Complexity
of Services

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Level 1: 25-49 Points; 5/10 Must Pass

- Demonstrates timely access and communication processes

- Organizes charts (paper or electronic) to facilitate team-based care and tracking age-appropriate and condition-specific interventions

- Identifies key clinical conditions among population served & follows evidence-based guidelines

- Encourages and provides support for patient/family self-management

- Addresses health literacy issues

- Tracks tests & referrals to assure completion

- Collects and reports on quality & satisfaction data to practice

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9

Four Critical Questions

1. **How do you know a PCMH when you see one?**

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3. **Will it improve quality and reduce cost?**

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Challenge: What Does it Co$t?

- **Varying Assumptions…**
  - **Future of Family Medicine 2004: Transition costs of $23,000 - $90,000 per physician***
    - **$15 PMPM for patients with chronic conditions**
  - **Ambulatory ICU: $40-50 PMPM for primary care – but assumes more complex patients**
- **Deloitte Analysis****
  - **Initial investment of $100,000/FTE**
  - **Ongoing expenses would increase $150,000 per year/FTE**
- **ACP/Commonwealth "Costing the Medical Home Study" – Report Fall 2008**
  - **Assess the incremental cost of building the medical home based on NCQA PPC-PCMH framework**

*http://www.annfammed.org/cgi/reprint/2/suppl_3/s1
**Deloitte: The Medical Home, Disruptive Innovation for a New Primary Care Model
Accessed at: http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf

Four Critical Questions

1. **How do you know a PCMH when you see one?**

2. **What does it cost?**

3. <u>**Will it improve quality and reduce cost?**</u>

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Will Quality Improve and Costs Decrease?

- **Each 1% increase in primary care associated with decrease of 503 admissions, 2968 ED visits, 512 surgeries*☼**

- **International & U.S. data demonstrate relationship between primary care and improved outcomes/reduced cost☼**

*Kravet, S et al: Health Care Utilization and the Proportion of Primary Care Physicians. Amer J of Medicine, 2008; 121:142-148.

Will Quality Improve and Costs Decrease?

- **A medical home can reduce or even eliminate racial and ethnic disparities in access and ☼ quality for insured persons through:**

  - Access to needed care

  - Receipt of routine preventive screenings

  - Management of chronic conditions

A.C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide:
How Medical Homes Promote Equity in Health Care: Results From
The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007

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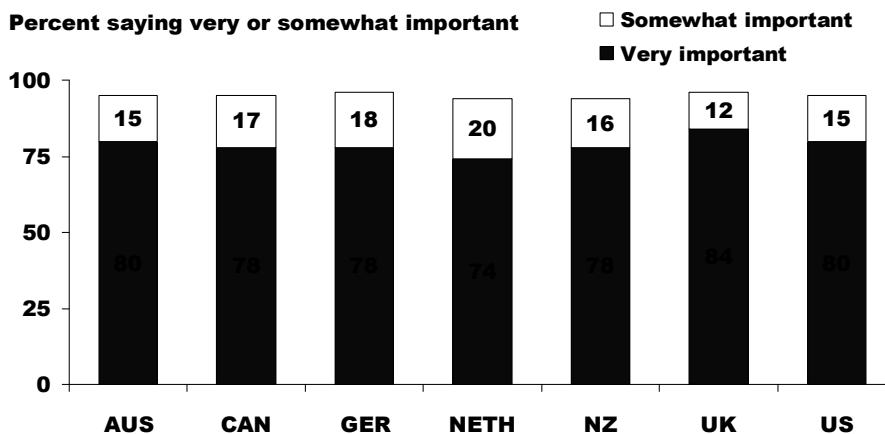
Indicators of a Medical Home (Adults 18 – 64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
Among those with a regular doctor or source of care . . .						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	(27)	28	34	15	26

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Adults Across Countries Place High Value on Having a "Medical Home"—Accessible, Personal, Coordinated Care

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Percent saying very or somewhat important

☐ Somewhat important
■ Very important

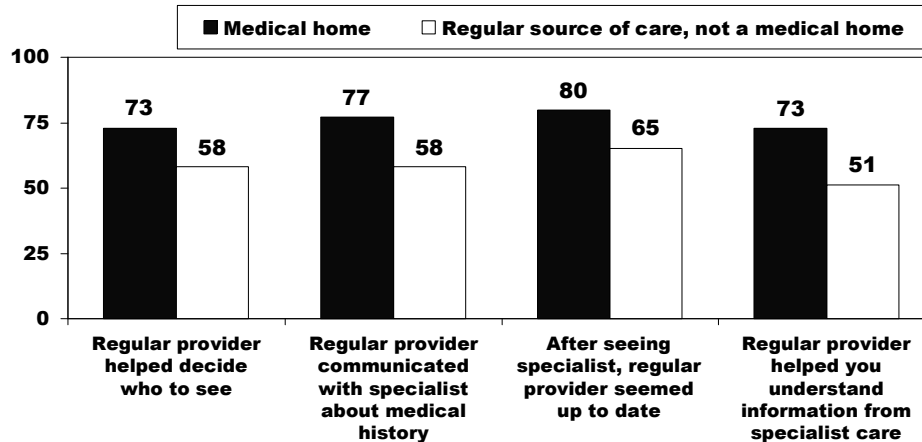|	AUS	CAN	GER	NETH	NZ	UK	US
Somewhat important	15	17	18	20	16	12	15
Very important	80	78	78	74	78	84	80

Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.
http://www.commonwealthfund.org/usr_doc/2007_11_Schoen_IHP_15.ppt?section=4934

THE COMMONWEALTH FUND

Patients with a Medical Home Report Better Coordination Between Their Regular Provider and Specialist

Percent of adults ages 18–64 who have seen a specialist in past two years

■ Medical home   □ Regular source of care, not a medical home

	Regular provider helped decide who to see	Regular provider communicated with specialist about medical history	After seeing specialist, regular provider seemed up to date	Regular provider helped you understand information from specialist care
Medical home	73	77	80	73
Regular source of care	58	58	65	51

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Potential Health System Impact

What will happen if it works?

Declining Interest

1. Primary care will stabilize – possibly grow
   a) More medical students & residents choose 1º care
2. Care coordination & referrals will be based on…
   a) Service responsiveness
   b) Partnership/Collaboration
   c) Performance
3. Patients will receive better care
   a) Less variability
   b) Improved relationship between cost & quality

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Specialty Care Connections

- **PCMH is NOT a gatekeeper system**

- **Jointly develop/identify referral guidelines**

- **Emphasis on transitions in care & continuity**

- **Some subspecialists may want to qualify as PCMH**

Expanding Interest in the PCMH

- **Patient-Centered Primary Care Collaborative**
  - 100+ organizations; represent 50+ million people
  - www.pcpcc.net
- **Articles in NEJM, Health Affairs, Annals of Internal Medicine**
- **Trade & Lay Press**
- **Legislation**
- **New entrepreneurs**

Demonstration Projects of PCMH

- **Multi-payer/multi-player commercial plans**

- **Medicaid transformation**

- **Medicare Advantage**

- **Medicare FFS**

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State Medicaid Innovation

- **As of January 25, 2008…**

  - **19 states trying to improve medical home availability in Medicaid/SCHIP programs**

  - **6 states have legislative authority or mandates to further medical home**

  - **8 states call for establishment of medical homes in Medicaid Transformation Grant applications**

  - **3 states have dedicated state resources to support medical homes**

Source: National Academy of State Health Policy (NASHP)
Preliminary report; 25 states reporting

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Common Themes of Demos

- ACP role: Convene, Catalyze, Collaborate, Consult

- Major success factor = local/regional leadership

- Market share & % of practice population covered

- Tests of reimbursement models

- External evaluator; transparency

- Measurements of quality, cost, satisfaction

Assessing Impact of Demos

- Clinical measures (AQA/NQF)

- Cost of care measures

- Satisfaction metrics

  - Patients

  - Clinicians

  - Staff

Payment Models for the PCMH
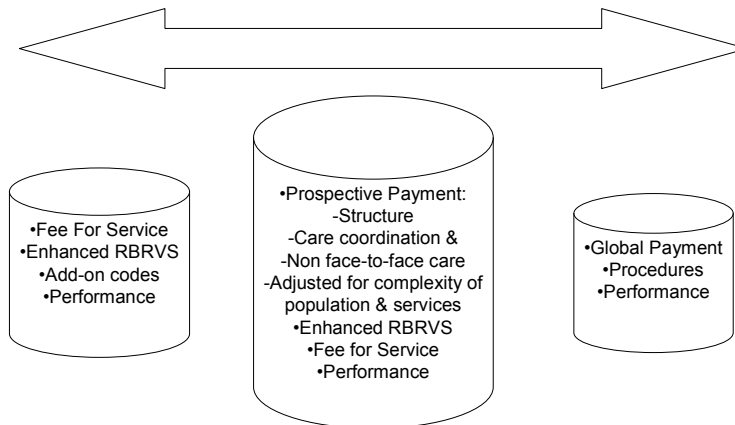
- Fee For Service
- Enhanced RBRVS
- Add-on codes
- Performance

- Prospective Payment:
  - Structure
  - Care coordination &
  - Non face-to-face care
  - Adjusted for complexity of population & services
- Enhanced RBRVS
- Fee for Service
- Performance

- Global Payment
- Procedures
- Performance

Patient-Centered Primary Care in Denmark

- **Blended primary care payment system**
  - **Fee-for-service**
  - **Medical home payment**
- **Organized off-hours service**
- **Health information technology**
  - **Reimbursement for email**
  - **Health information exchange; common portal**

Payment Model for Non-PCMH
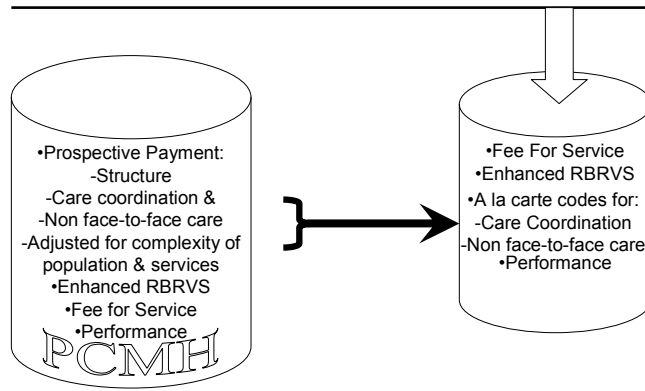
- •Prospective Payment:
  - -Structure
  - -Care coordination &
  - -Non face-to-face care
  - -Adjusted for complexity of population & services
- •Enhanced RBRVS
- •Fee for Service
- •Performance

PCMH

- •Fee For Service
- •Enhanced RBRVS
- •A la carte codes for:
  - -Care Coordination
  - -Non face-to-face care
- •Performance

Practice Implications

- **Need to understand challenges of transformation**

- **Initial capital and restructuring costs**

- **Ongoing support & maintenance**

- **Reporting on quality, cost and satisfaction**

- **Implementation of HIT coincident with PCMH**

Adoption of Health Information Technology

- **Many practices struggle with existing processes and technology**

- **Business case for wide adoption of electronic health records lacking**

- **Culture change**

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Barriers to Health Information Technology Adoption for Quality

- **Cost**

- **Lack of financial incentives***

- **Complexity of systems (lack of standards)**

- **Privacy, confidentiality and security**

- **Legal issues (e.g., Stark laws; medical liability)**

*Most important factor

Bates, D: The quality case for information technology in healthcare
BMC Medical Informatics & Decision Making 2002, 2:7

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HIT For:

Level 1: 25-49 Points; 5/10 Must Pass

- Demonstrates timely access and communication processes

- Organizes charts (paper or electronic) to facilitate team-based care and tracking age-appropriate and condition-specific interventions

- Identifies key clinical conditions among population served & follows evidence-based guidelines

- Encourages and provides support for patient/family self-management

- Addresses health literacy issues

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- Collects and reports on quality & satisfaction data to practice

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Demonstrates Timely Access & Communication Processes

- **Policies & Procedures: Set by practice**

- **Practice management system screen shots or tracking reports (spreadsheet, log book)**

- **Monitor appointment wait times & telephone call returns (spreadsheet, log book)**

- **Email statistics (if secure email is provided)**

Recall/Reminder resource: http://www.acponline.org/private/pmc/recall.doc

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Organizes Charts to Facilitate Care
(Percent of charts in past 3 months with 3 tools)

- **Problem lists**

- **Medication lists (OTC, Rx, other); short/long term**

- **Alternative Therapies**

- **Structured template for age-appropriate risk factors & screening tests**

- **Templates for progress notes**

Paper or electronic

&

Templates available
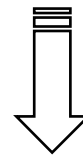
http://www.acponline.org/running_practice/quality_improvement/projects/cfpi/tools.htm

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Tracks Tests & Referrals

- **Tracks labs and tests until they are completed**

- **Flags overdue items**

- **Flags abnormal results – presents to clinician**

- **Notifies patient/family of abnormal results**

- **Notifies patient/family of normal results**

Paper or electronic

&

Templates available
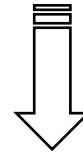
Referral Tracking Guide: http://www.acponline.org/pmc/managedcare.htm
Abnormal Result Notification log: http://www.acponline.org/running_practice/
quality_improvement/projects/cfpi/logs_abresults.pdf

Registries

- **A patient registry is a clinical information system that helps physicians and other health care providers identify and track patients with a defined disease or condition, such as diabetes**

- **Registries can also track age-appropriate screening, preventive care and other clinical metrics**

- **Registries can report quality indicators by physician and across the practice**

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http://diabetes.acponline.org/

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Email | tsumrall@msqio.sdps.org
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PATIENTS REPORTS CLINICS STAFF CUSTOM RULES ALERTS EXPORT INFO

COMorbid disease MANagement Database - COMMAND (Version III 06062005)

Subject Name	Sub Group	Type	Gender	Male Range		Female Range		Hide	Graph	Change	New
Height		Tests		0	0	0	0	☐	☑ M	☑	
HbA1c	Diabetes	Tests		3	6	3	6	☐	☑ M	☑	
MicroAlbumin	Diabetes	Tests		3.5	5	3.5	5	☐	☑ M	☑	
LVEF	HF	Tests		55	65	55	65	☐	☑ M	☑	
Cholesterol Total	Lipid Panel	Tests		0	200	0	200	☐	☑ M	☑	
HDL	Lipid Panel	Tests		35	100	35	100	☐	☑ M	☑	
LDL	Lipid Panel	Tests		0	130	0	130	☐	☑ M	☑	
Triglycerides	Lipid Panel	Tests		0	200	0	200	☐	☑ M	☑	
BP Diastolic	Vitals	Tests		0	90	0	90	☐	☑ M	☑	
BP Systolic	Vitals	Tests		0	140	0	140	☐	☑ M	☑	
Weight	Vitals	Tests		0	0	0	0	☐	☑ W	☑	
ACE		Medications						☐	☐	☑	
Peak FLOW		Tests						☐	☐	☑	
Anti-depressants		Medications						☐	☐	☑	
Antiplatelet Therapy		Medications						☐	☐	☑	
ARB		Medications						☐	☐	☑	
Beta-Blockers		Medications						☐	☐	☑	
Insulin		Medications						☐	☐	☑	

EBM

**Identify Key Clinical Conditions &
Follow Evidence-Based Guidelines**

- **Most frequent, most important risk factors, clinically important, or ongoing QI/reporting projects**

- **Use CMS Physician Quality Reporting Initiative Metrics***

- **Use practice specific data based on practice management system queries**

- **Base selection on national data**

* http://www.cms.hhs.gov/pqri/

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American College of Physicians   Home | Structured Search | Drug Resourc

pier Physicians' Information and Education Resource

Find: [   ] within Entire site

Quality Measures > Endocrinology, Diabetes, and Metabolism >

	Administrative Criteria	Background Medical Information
Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%	View	
Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)	View	
Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)	View	
Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which inlcuded documentation of the level of severity of retinopathy and the presence or absence of macular edema during one of more office visits within 12 months	View	
Measure #24: Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture: Percentage of patients aged 50 years and older treated for a hip, spine, or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	View	
Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months	View	View

http://pier.acponline.org - PIER Resources for Quality Measures - ...

Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)

What is the background medical information needed to implement this measure?

Diabetes Mellitus, Type 2 > Drug Therapy >

⊞ Adjust diabetes medications as needed to achieve target level of glycemic control. ©

Diabetes Mellitus, Type 1 > Drug Therapy >

⊞ Aggressively manage serum lipid levels. Ⓐ

Lipid Disorders (Dyslipidemia) : Table

©2008, Americ

Click to display tab

http://pier.acponline.org - Pier Ratings ...

Ratings   Close

Ⓐ The preponderance of data supporting this statement is derived from level 1 studies, which meet all of the evidence criteria for that study type.

Ⓑ The preponderance of data supporting this statement is derived from level 2 studies, which meet at least one of the evidence criteria

Click to displk   Internet

25

Health Care Industry Implications

- **Payers/Employers: Sponsor PCMH demonstration projects and test payment reform models**

- **Disease management companies: Explore direct relationships with physician practices**

- **Technology vendors: Demonstrate functionality, connectivity and ROI; technical assistance**

- **Pharmaceutical companies: Identify new strategies to engage physicians & office personnel; support practice transformation as well as condition-specific education and support**

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The Future

- **Multi-payer demonstration projects 2008**

- **More demonstration projects 2009**

- **Medicare Medical Home Demo 2009**

- **Support for practices**

- **Educational reform for students/residents**

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Thank You!

Michael S. Barr, MD, MBA, FACP
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